

# What's New? for Retirees FY 08/09



**Open  
Enrollment  
May 5<sup>th</sup>  
thru  
May 16<sup>th</sup>**

**Retiree  
Health  
Insurance  
Program**

*What are the "Right" plans for you?*





# TABLE OF CONTENTS

Glossary of Terms .....	4
Glossary of Acronyms.....	5
Retiree Open Enrollment Fairs.....	5
What's New? .....	5
Open Enrollment Period.....	9
Medical	
Plan Summary Chart.....	10
Copay/Co-insurance Comparison Chart .....	12
Pharmacy	
Co-insurance .....	14
Consumer Choice Plans.....	15
Additional Pharmacy Information.....	16
Vision	
EyeMed Vision Care.....	17
Dental	
Plan Summary Chart.....	18
Copay/Co-insurance Comparison Chart .....	19
How to look up a Physician or Dentist online .....	20
What happens if I don't complete Open Enrollment .....	21
Combined Rate Sheet .....	22
Contact Information .....	24



# GLOSSARY OF TERMS

**CIGNA Care Network (CCN):** A high performing cost effective specialty care provider network that includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. These providers are identified by a Tree of Life Symbol in the CIGNA provider directory.

**CIGNA Medicare Select Plus Rx:** CIGNA Medicare Advantage HMO plan with Prescription Drug benefits (previously called CIGNA for Seniors).

**CMG (CIGNA Medical Group Network):** A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

**CMG High and Low Plan:** A managed-care plan that requires members to use the CMG facilities for primary and most specialty and other services. Use of non-network providers or providers who practice in their own offices are not covered.

**Co-insurance:** A cost-sharing requirement under a health insurance policy, which provides that the insured will assume a percentage of the costs of covered services after payment of the deductible, if applicable.

**Copay:** A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as \$20 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of cost.

**Deductible(s):** Under a health insurance policy, amounts required to be paid by the insured either before benefits become payable, after a portion of benefits have been paid or for a specific benefit, before benefits are payable.

**Health Maintenance Organization (HMO):** HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals and other health professionals, who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

**High Option:** A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

**In-Network (or Network, Participating Provider):** Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees.

**Insured:** A person or organization covered by an insurance policy.

**Insurer (Insurance Company or vendor):** A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

**Low Option:** A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

**OAP (Open Access Plus) Plan:** A plan that gives options to use a network or non-network physician/provider each time the insured needs medical care, and does not require a referral to see a specialist.

**OAPIN (Open Access Plus) In-Network:** A plan that uses a network of providers who practice in their own offices and independently contract with CIGNA. Non-network physicians/providers are not covered under this plan. The OAP In-Network also includes the CMG network. A referral is not required to see a specialist.

**Out-of-Network (or Non-Participating, Non-Network Provider):** Health care received from a provider who is not contracted with the insured's health plan network.

**Out-of-Pocket Maximum:** The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties. Each plan summary lists the expenses that count towards the out-of-pocket maximum.

**Plan Year:** July 1 through June 30

**Preferred Medication List (aka Formulary):** List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

**Preventive Care Services:** This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary.

**Primary Care Physician (PCP):** A physician who practices general medicine, family medicine, internal medicine or pediatrics.

**Reasonable and Customary Charge (R&C):** The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

**Specialty Medication:** Usually are expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

# GLOSSARY OF ACRONYMS

Abbreviations used throughout this booklet

## C

**CCN:** CIGNA Care Network  
**CMG:** CIGNA Medical Group

## E

**EDS:** Employers Dental Services  
**EHI:** Employee Health Initiatives

## H

**HIPAA:** Health Insurance Portability and Accountability Act  
**HMO:** Health Maintenance Organization

## I

**ID:** Identification

**IRC:** Internal Revenue Code  
**IRS:** Internal Revenue Service

## M

**MH:** Mental Health  
**MST:** Mountain Standard Time

## O

**OAPIN:** Open Access Plus In-Network  
**OAP:** Open Access Plus  
**OE:** Open Enrollment

## P

**PCP:** Primary Care Physician  
**PHI:** Protected Health Information  
**PML:** Preferred Medication List

**PPO:** Preferred Provider Organization  
**PST:** Pacific Standard Time

## R

**RX:** Prescription

## S

**SPD:** Summary Plan Document  
**SSN:** Social Security Number

## U

**UV:** Ultraviolet

## W

**WHI:** Walgreens Health Initiatives

## 2008-2009 RETIREE OPEN ENROLLMENT FAIRS

Date	Location	Address	Time
Thursday, May 8	Public Health Administration	4041 N. Central Ave., Vista Room #613 Phoenix 85012	1 PM - 3 PM
Wednesday, May 14	Southeast Juvenile Court Center	1810 S. Lewis St., Saguaro Room Mesa 85210	1 PM - 3 PM

## WHAT'S NEW?

**ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009**

### CIGNA MEDICAL PLAN CHANGES\*\*

Changes to the medical plan offerings and copayments are listed below.

CMG (CIGNA Medical Group) High Option changes			CMG (CIGNA Medical Group) Low Option changes		
Service	Copay	Change	Service	Copay	Change
Preventive Care	\$0	Was \$15 / \$25	Preventive Care	\$0	Was \$25 / \$45
Allergy Injections	\$8* / \$23	Was \$25	Allergy Injections	\$13* / \$28	Was \$45
Specialty Care	\$25* / \$40	No change / Was \$25	Specialty Care	\$45* / \$60	No Change / Was \$45
Emergency Room	\$125	Was \$75	Emergency Room	\$125	Was \$100

OAPIN (Open Access Plus In-Network) changes		
Service	Copay	Change
Preventive Care	\$0	Was \$20 / \$30
Allergy Injections	\$10* / \$25	Was \$30
Specialty Care	\$30* / \$45	No Change / Was \$30
Emergency Room	\$125	Was \$100

OAP (Open Access Plus) High Option changes			OAP (Open Access Plus) Low Option changes		
In-Network Service	Copay	Change	In-Network Service	Copay	Change
Preventive Care	\$0	Was \$25 / \$35	Preventive Care	\$0	Was \$35 / \$50
Allergy Injections	\$13* / \$28	Was \$35	Allergy Injections	\$18* / \$33	Was \$50
Specialty Care	\$35* / \$50	No change / Was \$35	Specialty Care	\$50* / \$65	No change / Was \$50
Emergency Room	\$125	Was \$100	Emergency Room	\$150	No Change

\*\*Does not apply to CIGNA Medicare Select Plus Rx

# WHAT'S NEW? continued


ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009

## ***Preventive Care Services - \$0 Office Visit Copay***

This only applies to in-network services and includes the following:

- Routine Preventive Care for children and adults
- Routine Immunizations
- Routine Mammograms, PSAs, and Pap Smears

## ***\*CIGNA Care Network Specialist - Specialty Care Services - \$15 Office Visit Copay Differential***

When selecting in-network Specialty Care through a CIGNA Care Network (CCN) provider, the office visit is offered at a lower copayment. The CIGNA Care Network is a high-performing cost-effective specialty care network that meets certain criteria related to quality and efficiency. The CCN includes the following provider specialties: allergy/immunology, pulmonology, vascular surgery, cardiology, neurosurgery, orthopedics and surgery, urology, general surgery, ear, nose and throat, ophthalmology, rheumatology, infectious disease, gastroenterology and dermatology. CCN providers are identified by a Tree of Life Symbol  when you go online to [www.cigna.com](http://www.cigna.com) to search for a provider.

## ***Durable Medical Equipment – No Annual Limit***

For in-network services, there is no annual limit for Durable Medical Equipment. All Durable Medical Equipment must be medically necessary and a prior authorization is required for certain equipment.

## ***Allergy Injections – Lower Office Visit Copay***

For in-network services, a lower office visit copay applies for Allergy Injections administered by your Primary Care or CIGNA Care Network (CCN) Specialty Care Provider. Allergy Injections received from a non-CCN Specialty Care Provider are \$15 higher.

## ***PHARMACY PLAN CHANGES\*\****

### ***Delivery of Specialty Medication***

Specialty medication will be delivered only through Walgreens Specialty Pharmacy, a centralized mail order distribution center. Walgreens Specialty Pharmacy offers personalized care from an experienced Care Team of pharmacists and nurses trained in the complex health conditions and the latest medication therapies. A wide range of support services will be available to assist you with your specialty medication needs. Through these support services, you will receive personalized support that can help you get the best results from your prescribed therapy. These services are available to you at no cost. Retirees and/or dependents impacted by this change will receive a letter in May 2008.

### ***Changes that apply to the Co-Insurance Pharmacy Plan***

#### ***Non-Sedating Antihistamine (NSA) Step Care Therapy Program***

A Non-Sedating Antihistamine Step Care Therapy Program will be implemented. This program includes the following non-sedating antihistamine (NSA) medications: Allegra, Allegra-D® 12 Hour, Allegra-D® 24 Hour, fexofenadine, Clarinex®, Clarinex-D® 12 Hour, Clarinex-D® 24 Hour, Clarinex-D® Redi-Tab, or Xyzal®. This Step Care Therapy Program requires you to first try the over-the-counter options—Claritin (loratadine) and Zyrtec (cetirizine)—before filling a prescription for a NSA medication. In many cases, these over-the-counter NSA medications are as effective as the prescription NSA medications, and cost less for you and your dependents.

If you or your dependents have already tried an over-the-counter NSAs and your doctor says you require a prescription NSA, please call the WHI Clinical Call Center at (877) 665-6609, Monday through Friday, 8:00 AM - 8:00 PM CDT, to start the prior authorization process. Retirees who are impacted by this change, will receive a letter by June 2008.

#### ***Xyzal® will be considered Tier 3 or Non-Preferred Brand***

In addition, Xyzal® will be considered Tier 3 or non-preferred brand on the Preferred Medication List (PML) and will be subject to the highest co-insurance level. A 30-day supply of a non-preferred drug with no generic equivalent such as Xyzal will have a 50% co-insurance. The lower cost, Tier 1, generic alternative is fexofenadine.

***\*\*Does not apply to CIGNA Medicare Select Plus Rx***

# WHAT'S NEW? continued

**ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009**

## DENTAL PLAN CHANGES

### *CIGNA Dental Progressive/Regressive Feature*

The CIGNA Dental plan will be enhanced to include a progressive/regressive wellness incentive that will apply to dental services provided in-network and out-of-network. Preventive care services received in one plan year are rewarded with higher benefit percentages the next plan year. The benefit level increases year after year as retirees and/or dependents receive preventive care. When preventive care is not received, the benefit percentage decreases in the following year; however, the benefit percentages will never fall below the base plan design which is effective 07/01/08.

The plan is designed to encourage good dental care for you and/or your dependents. Therefore, the increase/decrease (progression/regression) in benefit is tracked at an individual member level and the increase only applies to those family members that receive Preventive Care Services.

The base plan summary by class for Year One, effective 07/01/08, is defined below. For a detailed benefits summary, please turn to page 18.

Year One - Effective 7/01/08 - Base Plan

Benefit Level	In-Network		Out-of-Network	
	Plan	Retiree	Plan	Retiree
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
<b>Class II - Basic Restorative Care</b>	<b>80%</b>	<b>20%</b>	<b>60%</b>	<b>40%</b>
<b>Class III - Major Restorative Care</b>	<b>50%</b>	<b>50%</b>	<b>50%</b>	<b>50%</b>
Class IV - Orthodontia	50%	50%	50%	50%

### *Progressive Feature*

Preventive Care Services (Class I) received in Year One are rewarded with high benefit percentages for Basic Restorative Care (Class II) and Major Restorative Care (Class III) for both in-network and out-of-network services. Progression increments are 5% per year and will not exceed the maximum benefit level in Year Three, which is 90% (in-network) and 70% (out-of-network) for Class II and 60% Class III (in- and out-of-network).

For example, if you receive Preventive Care Services (Class I) during Year One (Base Plan), your plan design for Year Two is defined below:

Year Two - Effective 7/01/09

Benefit Level	In-Network		Out-of-Network	
	Plan	Retiree	Plan	Retiree
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
<b>Class II - Basic Restorative Care</b>	<b>85%</b>	<b>15%</b>	<b>65%</b>	<b>35%</b>
<b>Class III - Major Restorative Care</b>	<b>55%</b>	<b>45%</b>	<b>55%</b>	<b>45%</b>
Class IV - Orthodontia	50%	50%	50%	50%

If you receive Preventive Care Services (Class I) during Year Two, your plan design for Year Three is defined below:

Year Three - Effective 7/01/10

Benefit Level	In-Network		Out-of-Network	
	Plan	Retiree	Plan	Retiree
Class I - Preventive & Diagnostic Care	100%	0%	80%	20%
<b>Class II - Basic Restorative Care</b>	<b>90%</b>	<b>10%</b>	<b>70%</b>	<b>30%</b>
<b>Class III - Major Restorative Care</b>	<b>60%</b>	<b>40%</b>	<b>60%</b>	<b>40%</b>
Class IV - Orthodontia	50%	50%	50%	50%



# WHAT'S NEW? continued

**ALL CHANGES STATED HEREIN ARE EFFECTIVE JULY 1, 2008 THROUGH JUNE 30, 2009**

## *Regressive Feature*

When Preventive Care Services (Class I) are not received, the benefit percentages for Basic Restorative Care (Class II) and Major Restorative Care (Class III) will decrease the following year. Regression decrements are 5% and will not fall below the Base Plan Year.

## *Illustrations*

Below are 3 different illustrations:

### ILLUSTRATION 1

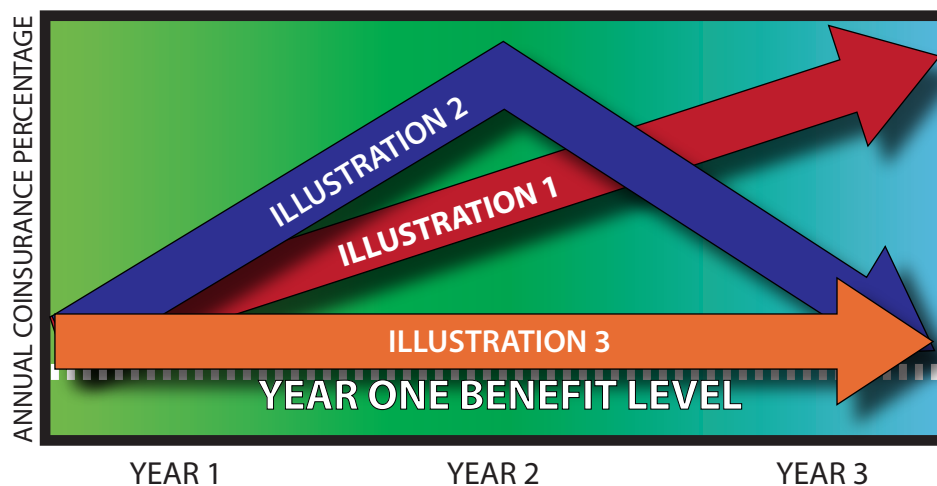
If you receive preventive care every plan year, your benefit level will increase the following plan year until it reaches the maximum level - year 3.

### ILLUSTRATION 2

If you receive preventive care in plan year 1, your benefit level will increase in year 2. If you do not receive preventive care in year 2, your benefit level in year 3 will return to year 1 benefit level.

### ILLUSTRATION 3

If you never receive preventive care, your benefit level will remain the same and never decrease below your base plan year.



## QUESTIONS?

Refer to the contact information page provided at the end of this booklet

Call the Employee Health Initiatives Department at

(602) 506-1010 from 8 AM to 5 PM Monday-Friday for benefit questions.



# OPEN ENROLLMENT PERIOD

This Open Enrollment period, your benefit elections and premium rates are effective for a 12-month period, beginning July 1, 2008 and ending June 30, 2009. The next time you can change your benefits will be the next Open Enrollment in May 2009.

## WHEN?

**Open Enrollment begins** Monday, May 5, 2008 through Monday, May 16, 2008

Enrollment forms must be mailed or faxed to The Employee Health Initiatives Department no later than May 16, 2008. Forms delivered by U.S. Postal Service must be postmarked by May 16, 2008. **Late enrollments will not be accepted. If you do not want to make changes to your current elections, you do not need to complete the Open Enrollment form. Your benefits will continue uninterrupted.**

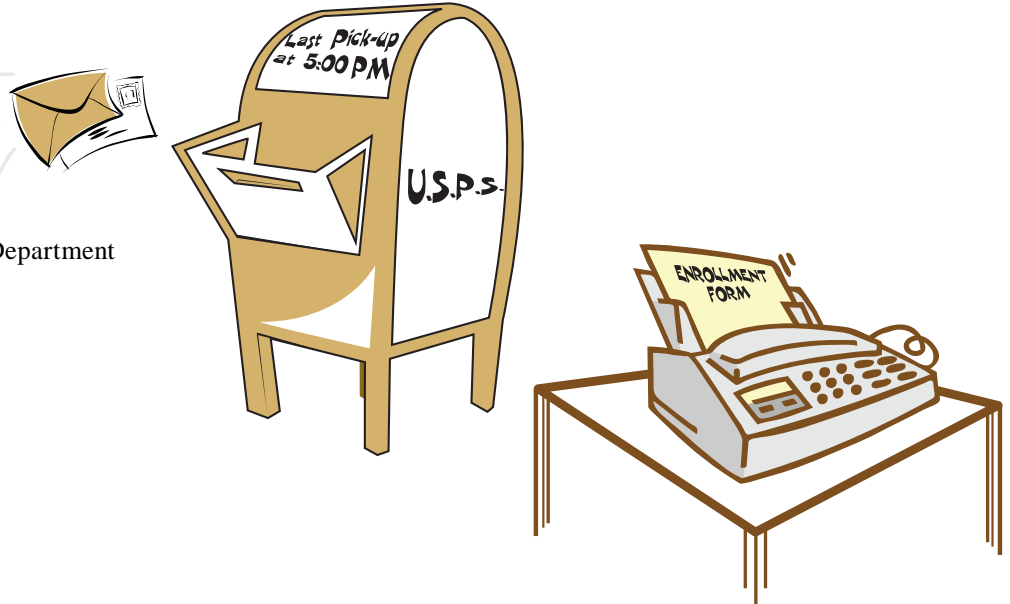
## HOW?

Mail or fax your enrollment form to:

Maricopa County  
Employee Health Initiatives Department  
301 West Jefferson Street  
Suite 201  
Phoenix, AZ 85042

Phone: (602) 506-1010

Fax: (602) 506-2354

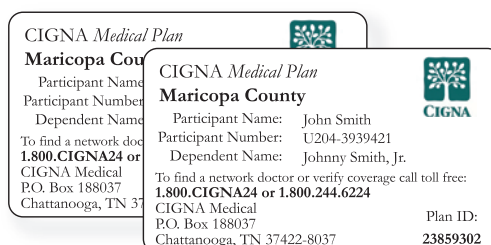


## WHERE DO I GET ADDITIONAL INFORMATION NOT CONTAINED IN THIS GUIDE?

While most of the information you need is contained in this guide, other pertinent information is available online at the Benefits Home Web site located at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits). The Benefit vendors are your primary and best source of information regarding the plans they offer. Refer to the "Who to Contact" section for their telephone numbers and Web site addresses.

## WHEN WILL I RECEIVE NEW INSURANCE ID CARDS?

- New CIGNA Medical ID cards will be issued to all enrollees for all medical plans. CIGNA issues an individual ID card for each enrollee.
- New ID cards will be issued to new enrollees in the pharmacy or vision benefit, and EDS or Delta Dental plans. The ID cards from these vendors either 1) contain the names of all covered dependents or 2) contain only the insured's name and can be used for all covered dependents.
- There are no personalized ID cards for Magellan Health Services or CIGNA Dental. These ID cards are available through the Employee Health Initiatives Department.



## MEDICAL PLAN SUMMARY CHART

Benefit Provision	CIGNA Medical Group High (CMG High):	CIGNA Medical Group Low (CMG Low):	Open Access Plus In-Network (OAPIN):
Type of Plan	<u><a href="#">HMO</a></u>	<u><a href="#">HMO</a></u>	<u><a href="#">HMO</a></u> with Open Access to Specialists
Service Area Where Care Must be Received	Maricopa County only, except for emergency care	Maricopa County only, except for emergency care	Nationally
Residency Requirement	Must work or reside in Maricopa County	Must work or reside in Maricopa County	None
Primary Care Physician (PCP) Required	Yes; May only use PCP's who practice in CIGNA Medical Group Centers	Yes; May only use PCP's who practice in CIGNA Medical Group Centers	No
Referral Required	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine	No
Out-of-Network Coverage	No	No	No
Network	AZ-CIGNA Medical Group Network AZ812	AZ-CIGNA Medical Group Network AZ812	National Open Access Plus AZ300
Prior Authorization	Provider's responsibility	Provider's responsibility	Provider's responsibility

For more detail, review the CIGNA medical plan summaries on the Open Enrollment tab of the EHI web site [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

## MEDICAL PLAN SUMMARY CHART

Benefit Provision	Open Access Plus High (OAP High):	Open Access Plus Low (OAP Low):	CIGNA Medicare Select Plus Rx* (previously called CIGNA for Seniors):
Type of Plan	<u>HMO</u> with Open Access to Specialists	<u>HMO</u> with Open Access to Specialists	<u>HMO</u>
Service Area Where Care Must be Received	Nationally	Nationally	Maricopa County
Residency Requirement	None	None	You must reside in Maricopa County
PCP Required	No	No	Yes, CIGNA Medical Group PCP only
Referral Required	No	No	Yes, except to obstetrician/ gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine
Out-of-Network Coverage	Yes	Yes	No
Network	National Open Access AZ300	National Open Access AZ300	AZ-CIGNA Medical Group Network AZ805
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.	Provider's responsibility

\*Must be enrolled in Medicare Parts A & B coverage.

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# MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		CIGNA Medical Group High (CMG High):	CIGNA Medical Group Low (CMG Low):	Open Access Plus In-Network (OAPIN):
		<i>In-Network Coverage Only</i>		
Deductible	Individual	None	None	None
	Family	None	None	None
Standard Percent of Co-insurance		N/A	90%	N/A
Out-of-Pocket Maximum	Individual	\$1,000	\$5,000	\$1,000
	Family	\$2,000	\$10,000	\$2,000
Pre-existing Condition Limitation		None	None	Yes, same as for OAP High & Low Options
Preventive Care		\$0 (FREE)	\$0 (FREE)	\$0 (FREE)
Primary Care Physician Services		\$15	\$25	\$20
Specialty Care Physician Services		\$25* / \$40	\$45* / \$60	\$30* / \$45
Advanced radiology: CT, PET, MRI, MRA Scans/type of scan/day and nuclear cardiac studies**		\$50	\$100	\$100
Allergy Injections		\$8* / \$23	\$13* / \$28	\$10* / \$25
Outpatient Lab and X-ray		\$0	\$0	\$0
Inpatient Facility Charges		\$100/admit	\$500/admit, then 10%	\$200/admit
Inpatient Physician and Surgeon's Services		\$0	\$0	\$0
Outpatient Facility Services		\$0	\$250, then 10%	\$100
Pre- & Postnatal Exams (after pregnancy has been determined)		\$25, waived after 1st visit	\$45, waived after 1st visit	\$30, waived after 1st visit
Delivery		\$100	\$500, then 10%	\$200
Urgent Care		\$35, waived if admitted	\$50, waived if admitted	\$50, waived if admitted
Emergency Room		\$125, waived if admitted	\$125, waived if admitted	\$125, waived if admitted
Ambulance		\$0	\$0	\$0
Durable Medical Equipment - <b>No annual limit</b>		\$0	\$0	\$0
External Prosthetics		\$0	\$0	\$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr.		\$25/provider/day***	\$45/provider/day***	\$30/provider/day
Cardiac Rehab; 36 visits/yr.		\$25 per visit	\$45 per visit	\$30 per visit
Alternative Medicine; 20 visits/yr. \$60 credit for supplies/products		\$15 per visit	\$25 per visit	\$20 per visit
Behavioral Health/Pharmacy		Magellan/WHI	Magellan/WHI	Magellan/WHI

For more detail, review the CIGNA medical plan summaries on the Open Enrollment tab of the EHI web site [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

\*CIGNA Care Network Specialist

\*\*Advanced radiology copays apply in addition to inpatient, outpatient and emergency room copays or co-insurance.

\*\*\*Chiropractic visits have a separate 60 visit limit per year. Other therapies have a combined 60 visit per year.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

# MEDICAL COPAY/CO-INSURANCE COMPARISON CHART

Open Access Plus High (OAP High):		Open Access Plus Low (OAP Low):		CIGNA Medicare Select Plus Rx (previously called CIGNA for Seniors):
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
None	\$500	None	\$1,000	\$0
None	\$1,000	None	\$2,000	\$0
N/A	70% of reasonable and customary	90%	70% of reasonable & customary	N/A
\$1,500	\$3,000	\$5,000	\$10,000	N/A
\$3,000	\$6,000	\$10,000	\$20,000	N/A
12 months for treatment in prior 60 days. Waived with certificate of creditable coverage and for retirees currently covered by a county medical plan for at least 12 months. Certificate of creditable coverage must be sent to CIGNA and also provided to the EHI Department.				
\$0 (FREE)	Covered in-network only	\$0 (FREE)	Covered in-network only	\$0 (FREE)
\$25	30% after deductible	\$35	30% after deductible	\$0 (FREE)
\$35* / \$50	30% after deductible	\$50* / \$65	30% after deductible	\$12
\$100	30% after deductible	10%	30% after deductible	\$0 (FREE)
\$13* / \$28	30% after deductible	\$18* / \$33	30% after deductible	\$12
\$0	30% after deductible	10%	30% after deductible	\$0 - \$12
\$250/admit	30% after deductible	\$1,000/admit, then 10%	\$2,000/admit, then 30%	\$0 (FREE)
\$0	30% after deductible	10%	30% after deductible	\$0 (FREE)
\$100	30% after deductible	\$500, then 10%	\$1,000/admit, then 30% after deductible	\$12
\$35, waived after 1st visit	30% after deductible	\$50, then 10%	30% after deductible	N/A
\$250	30% after deductible	\$1,000, then 10%	\$2,000, then 30% after deductible	N/A
\$50, waived if admitted	\$50, waived if admitted	\$75, waived if admitted	\$75, waived if admitted	\$0 - CMG & contracted in-area Urgent Care Centers \$25 - non-contracted & out-of- area Urgent Care Centers
\$125, waived if admitted	\$125, waived if admitted	\$150, waived if admitted	\$150, waived if admitted	\$50
\$0	\$0	10%	10%	\$0 (FREE)
\$0	30% after deductible	10%	30% after deductible	\$0 (FREE)
\$0	30% after deductible	10%	30% after deductible	\$0 (FREE)
\$35/provider/day	30% after deductible/ provider/day	\$50/provider/day	30% after deductible/ provider/day	\$12
\$35 per visit	30% after deductible	\$35 per visit	30% after deductible	\$12
\$25 per visit	Covered in-network only	\$35 per visit	Covered in-network only	N/A
Magellan/WHI	Magellan/WHI	Magellan/WHI	Magellan/WHI	CIGNA Behavioral Health/ CIGNA Pharmacy

For more detail, review the CIGNA medical plan summaries on the Open Enrollment tab of the EHI web site [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

\*CIGNA Care Network Specialist

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.



## PHARMACY PLANS

### *Administered by Walgreens Health Initiatives (WHI)*

If you enroll in a medical plan, except for the CIGNA Medicare Select Plus Rx plan, you must enroll in one of the pharmacy plans below. However, you may not enroll your dependents in a pharmacy plan if they are not enrolled in your medical plan.

#### ***Co-insurance Benefit Plan***

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost<sup>1</sup> of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medication. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility and cosmetic medications, are excluded. You are responsible for paying 100% of the contracted cost for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. If you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the medications.

The co-insurance or the minimum or maximum copay you pay toward any covered medication apply to your out-of-pocket maximum except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent will not count. The out-of-pocket limit is \$1,500 for an individual and \$3,000 for a family<sup>2</sup>. Once the out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and its generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family <sup>2</sup>				
	Classification	Up to 30-Day Supply		
Level 1	Generic	\$2 Minimum	25% Co-insurance <sup>1</sup>	\$12 Maximum <sup>3</sup>
Level 2	Preferred Brand	\$5 Minimum	30% Co-insurance <sup>1</sup>	\$30 Maximum <sup>3</sup>
Level 3	Non-Preferred Brand with Generic equivalent	\$20 Minimum	50% Co-insurance <sup>1</sup> +	Difference between brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	\$20 Minimum	50% Co-insurance <sup>1</sup>	
Level 5	Non-Preferred Brand Specialty Drugs	\$50 Copay		

<sup>1</sup> Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to [www.mywhi.com](http://www.mywhi.com)

<sup>2</sup> Family refers to retiree and one or more covered dependents.

<sup>3</sup> Maximums are reduced when mail service is used.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the EHI Web site under the Open Enrollment tab at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

## Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County funded pharmacy account. The County will place \$300 in an Individual account or \$500 in a Family account (family in this case is defined as more than 1 person covered). In terms of Family coverage, the \$500 is available to whichever family members use the pharmacy benefit on a first come, first served basis and no one individual on a Family plan may exceed \$300 of the allocated \$500.
- Level 2 consists of the Retiree deductible portion and begins when the \$300 Individual or \$500 Family amount in Level 1 is exhausted. Retirees must then meet their deductible of \$300 for an Individual or \$500 for a Family before moving to the next level. Individuals insured under a Family plan who reach \$300 of the \$500 deductible are able to move to the Level 3 benefit while the rest of the family must remain at Level 2 until the additional \$200 is met.
- Level 3 is more like your traditional insurance coverage where the County pays 80% of the cost of the medication and you pay 20% of the cost for the remainder of the benefit year.
- Level 4 is limited to specialty medications only and consists of a \$50 copayment. Specialty medication copayments are not charged against any of the first 3 levels.

For further clarification on the Consumer Choice Pharmacy Plan, please refer to the Pharmacy Benefit Plan booklet found at:

[www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, cosmetics, smoking cessation and non-steroid anti-inflammatory medications are excluded.

The amounts you pay toward any covered medication will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is \$1,500 for individual coverage or \$3,000 for family<sup>2</sup> coverage. Once the out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum \$1,500 Single / \$3,000 Family <sup>2</sup>					
	<i>Certain generic preventive medications are provided at no cost. List available at <a href="http://www.maricopa.gov/benefits">www.maricopa.gov/benefits</a>.</i>				
Level 1	Pharmacy Account	Individual Family <sup>2</sup>	\$300 Individual \$500 Family	100% Maricopa County paid <sup>1</sup>	Any unused amount is carried over to next plan year
Level 2	Retiree Responsibility	Individual Family <sup>2</sup>	\$300 Individual \$500 Family	100% Retiree paid <sup>1</sup>	
Level 3	Traditional Insurance Coverage			20% <sup>1</sup> covered by Retiree	80% <sup>1</sup> covered by Maricopa County
Level 4	Specialty Drug	\$50 copay; does not apply to pharmacy account, retiree responsibility or insurance levels; Copay applies to out-of-pocket maximum.			

<sup>1</sup> Cost of medication is calculated by average wholesale price - discount or maximum allowable cost + dispensing fee. Discount amount varies by place of service and number of days supplied. To find the lowest cost for medication between retail, Advantage90™ and mail service, go to [www.mywhi.com](http://www.mywhi.com)

<sup>2</sup> Family refers to retiree and one or more covered dependents.

<sup>3</sup> Maximums are reduced when mail service is used.

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the EHI Web site under the Open Enrollment tab at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).





## Co-insurance Benefit Plan & Consumer Choice Benefit Plan

**THREE-MONTH SUPPLY AT CERTAIN RETAIL PHARMACIES – ADVANTAGE90™** When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at any pharmacy located in a retail pharmacy participating in Advantage90™ or through mail service, after two fills of 30 or less days supply of a maintenance medication at a retail pharmacy. The physician must write your prescription for an 84-91 day supply. Refer to [www.mywhi.com](http://www.mywhi.com) for a list of pharmacies participating in Advantage90™. Your cost for a three-month supply at an Advantage90™ retail pharmacy is may be slightly less than three times the one-month supply copay or co-insurance.

**THREE-MONTH SUPPLY THROUGH THE MAIL SERVICE PHARMACY** Prescriptions for maintenance medications or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save more money! Maximum copayments and co-insurance for the Co-insurance plan are reduced when mail service is used. Level One (generic) has 15% co-insurance with a maximum of \$28, and Level Two (preferred brand) has 25% co-insurance with a maximum of \$70. For the Consumer Choice Plan, you may save money as many of the medications, especially generics, have a higher discounted contracted cost than medications filled at a retail or Advantage90™ pharmacy. You must use a specific order form when placing your first order so as to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the Tempe Registration and Order Form and is available online at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits) or at [www.mywhi.com](http://www.mywhi.com).

If purchasing medication in a three-month supply is financially problematic, please consider enrolling in the CIGNA Medicare Select Plus Rx medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities.

**\*Note:** Diabetic supplies and medications may be obtained at a CIGNA Medical Group pharmacy for \$10 per item for a 30-day supply. Please show your CIGNA ID card since these costs will be charged to your medical plan instead of your pharmacy plan.

## CIGNA Pharmacy Plan for CIGNA Medicare Select Plus Rx

If you enrolled in the CIGNA Medicare Select Plus Rx Medical plan, your pharmacy benefit is provided through CIGNA instead of WHI. The CIGNA plan consists of a four-level copay plan.

		Retail	Mail
Level 1	Generic	\$15	\$40
Level 2	Preferred Brand	\$30	\$85
Level 3	Non-Preferred Brand	\$30	\$85
Level 4	Specialty Medication	\$30	\$85
Certain generic and preferred brand preventive medications are provided at no cost (Deductible does not apply to these preventive medications).			

Cost of pharmacy plan included in medical premium for CIGNA Medicare Select Plus Rx plan. Refer to [www.cigna.com](http://www.cigna.com) for a list of medications by level.

The pharmacy benefit for CIGNA Medicare Select Plus Rx plan is administered by:



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Contact Walgreens Health Initiatives for additional information, or view the detailed [Pharmacy Summary Plan](#) document available on the EHI Web site under the Open Enrollment tab at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

\*Does not apply to CIGNA Medicare Select Plus Rx plan

# VISION PLAN

## *Administered by EyeMed Vision Care*

You are automatically enrolled in a vision coverage when you enroll in a CIGNA medical plan with the exception of the CIGNA Medicare Select Plus Rx plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
<b>Exam with Dilation as Necessary</b>	\$10 Copay	\$35
<b>Exam Options:</b> Standard Contact Lens Fit and Follow-Up* Premium Contact Lens Fit and Follow-Up**	Up to \$55 10% off retail price	N/A N/A
<b>Frames:</b> Any available frame at provider location	\$130 allowance, 20% off balance over \$130	\$50
<b>Standard Plastic Lenses:</b> Single Vision Bifocal Trifocal Lenticular	\$10 Copay \$10 Copay \$10 Copay \$10 Copay	\$25 \$40 \$55 \$55
<b>Lens Options:</b> UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (Add-on to Bifocal) Other Add-ons and Services	\$15 \$15 \$15 \$0 \$45 \$65 20% off retail price	N/A N/A N/A \$25 N/A N/A N/A
<b>Contact Lenses:</b> (Contact lens allowance covers materials only) Conventional Disposable Medically Necessary	\$0 Copay, \$130 allowance, 15% off balance over \$130 \$0 Copay, \$130 allowance, plus balance over \$130 \$0 Copay, Paid-in-Full	\$130 \$130 \$250
<b>Laser Vision Correction</b>	\$150 allowance; once per lifetime per eye	N/A
<b>Frequency:</b> Examination Frame Lenses or Contact Lenses	Once every 12 months Once every 12 months Once every 12 months	

\*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement

(Examples include but not limited to disposable, frequent replacement, etc.)

\*\*Premium Contact Lens Fitting - all lens designs, materials and speciality fittings other than Standard Contact Lenses

(Examples include toric, multifocal, etc.)

### ***Additional Discounts:***

Member will receive a 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered. Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.

Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA vision.

Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com). The contact lens benefit allowance is not applicable to this service.

## DENTAL PLAN SUMMARY CHART

Benefit Provision	EDS	CIGNA Dental	Delta Dental
Type of Plan	<u><a href="#">DCO</a></u> (Dental Care Organization)	<u><a href="#">PPO</a></u>	<u><a href="#">PPO</a></u> (but does not use PPO network; see network below.)
Service Area Where Care Must be Received	Maricopa County	Nationally	Nationally
Residency Requirement	No	No	No
Primary Care Dentist Required	Yes, all family members must choose the same dentist	No	No
Referral Required	No	No	No
Out-of-Network Coverage	No	Yes	Yes
Network	EDS Provider Network	CIGNA Dental Network	Delta Premier Network
Prior Authorization	No	No, predetermination recommended for services over \$250	No, predetermination recommended for services over \$250
Location of Provider Directory	<u><a href="http://www.mydentalplan.net">www.mydentalplan.net</a></u>	<u><a href="http://www.cigna.com">www.cigna.com</a></u>	<u><a href="http://www.deltadentalaz.com">www.deltadentalaz.com</a></u>

***You may enroll in a dental plan only if you enroll in a medical plan***

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

## DENTAL COPAY/CO-INSURANCE COMPARISON CHART

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	\$0	\$50		\$50	
	Family	\$0	\$100		\$100	
Annual Individual	Standard	None	\$2,000		\$2,000	
Benefit Maximum	Orthodontic	None	\$3,000		\$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Class I - Preventive Care Services			Amount Paid by the Member			
Preventive Care Routine Cleanings Sealants Space Maintainers		\$0 \$12/tooth \$20 + lab fees	In-Network	Out-of-Network**	In-Network	Out-of-Network**
			Deductible waived			
			\$0	20%	\$0	\$0
Diagnostic Exams Evaluations Consultations & X-rays		Copay \$0-\$20	Deductible waived			
			\$0	20%	\$0	\$0
			Deductible waived			
Emergency Palliative Treatment Treatment for the relief of pain		Up to \$200 reimbursement less applicable copay	Deductible waived			
			\$0	20%	\$0	\$0
Class II - Basic Restorative Services			Amount Paid by the Member			
Restorative Fillings		Amalgam \$8-\$21 Resin \$22-\$40	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
			Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery Extractions		From \$35	20%	40%	20%	20%
Endodontics Root Canal Treatment Pulpotomy		Copay \$170-\$265	20%	40%	20%	20%
Periodontics Treatment of gum disease Periodontal Maintenance		Debridement: \$80 Root Planing: \$90	20%	40%	20%	20%
Bridge & Denture Repair		\$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			Amount Paid by the Member			
Prosthodontics Bridges per pontic Partial Dentures Complete Dentures (upper or lower)		\$250 + lab fees \$375 + lab fees \$325 + lab fees	50%		50%	
Restorative Cast Crowns & Jackets Onlays & Inlays		\$250 + lab fees \$135 - \$170	50%		50%	
Class IV - Orthodontic Services			Amount Paid by the Member			
Orthodontic maximum is separate from annual benefit maximum		25% discount children & adults	50% children & adults		50% Adults & children age 8 + older	

\*Specialist Care & treatment of TMJ are offered at a discount.

\*\*If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount in addition to the applicable deductible and co-insurance.

\*\*\* Progressive/Regressive Base Plan. If you enroll in this plan, if you receive a preventive service during FY 08-09 plan year you increase your level of coverage for the next plan year.

For more detail, review the dental plan documents under the Open Enrollment tab at [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits).

# HOW TO LOOK UP A PHYSICIAN OR DENTIST ONLINE

## ***CIGNA Medical and Dental Plans – Start at [www.cigna.com](http://www.cigna.com)***

1. From the home page, select the Provider Directory link (at top of screen)
2. For medical, enter your physician search information  
For dental, select the radio button next to Dentist and enter the search information
3. Click on the “Next” button
4. Continue with the applicable instructions below



Remember to look for the Tree of Life symbol  to identify CIGNA Care Network Specialists for a lower copay.

## ***CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812***

1. On the next page, under the “What type of plan you have” section, choose “Network (HMO) Plans or Point of Service (POS) Plans”
2. From the “Network (HMO) Plans or Point of Service (POS) Plans” drop-down list, select AZ-CIGNA Medical Group
3. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
4. Click on the “Search” button to view the provider search response

## ***OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300***

1. On the next page, under the “What type of plan you have” section, choose “Open Access Plus Only”
2. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
3. Click on the “Search” button to view the provider search response

## ***CIGNA Medicare Select Plus Rx use the the AZ – CIGNA Medical Group Network AZ812***

1. On the next page, under the “What type of plan you have” section, choose “Network (HMO) Plans or Point of Service (POS) Plans”
2. From the “Network (HMO) Plans or Point of Service (POS) Plans” drop-down list, select AZ-Medicare
3. Under “What you’re looking for” section, select “Primary Care Physician” or “Specialist” and the type from the corresponding drop-down list
4. Click on the “Search” button to view the provider search response
5. Or call 1-800-592-9231, select 1, select 1 again to speak to a representative.

## ***CIGNA Dental***

On the next page, under “What type of plan you have” section, choose “Managed care plan with open access to dentists for CIGNA Dental PPO” and the type from the drop-down list. Click on the “Search” button to view the dental search response.

## ***Other Dental Plans***

### **EDS**

1. Start at [www.mydentalplan.net](http://www.mydentalplan.net)
2. From the Home page, under the Members Tool section, click on the “Dentist Search” link
3. You can search by city, dentist’s last name or download a provider directory

### **Delta Dental**

1. Start at [www.deltadentalaz.com](http://www.deltadentalaz.com)
2. Click on Dentist and then Dentist Search
3. When a new page appears, under “1. Product Selection”, select “Dental Premier” and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

# DISCLAIMER

*Carefully read the information in this guide.*

**Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's network because physicians and dentists may stop participating during the plan year.**

If a specific physician or dentist is very important to you, consider selecting a product with out-of-network benefits such as an Open Access Plus (OAP) High or Low option and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to see providers who no longer participate with the vendor's network, at higher out-of-pocket costs to you. Additionally, you should not make your pharmacy election solely on the basis of specific medications on the preferred medication list because medication coverage status may change during the plan year. For example, medications may change from preferred brand name level to a generic or non-preferred brand name level, or may become available over-the-counter and therefore will not be covered under the pharmacy benefit.

Make your election decisions carefully as they cannot be changed until July 1, 2009. (Keep a copy of your enrollment form as verification of your Open Enrollment elections.)

Once all enrollment elections are processed, a confirmation statement will be produced and mailed in early June.

Review your confirmation statement immediately and contact Employee Health Initiatives no later than June 30, 2008, if you discover an error.

Watch for your new ID card in the mail and upon receipt, be sure to check the PCP. After July 1, 2008, contact your selected medical plan vendor to change your primary care provider (PCP), if applicable. Destroy your old ID card upon receipt of your new card. If additional cards are needed, contact the vendor directly either by phone or through their Web site. See the "Who to Contact" section.

# COMBINED RATE SHEET

## Monthly Total Medical Rates

(Rates include CIGNA medical, WHI pharmacy, Magellan behavioral health and EyeMed vision coverage)

### Medical

CMG High option + Co-insurance Rx	
Retiree (over age 65)	\$1,134.90
Retiree (under age 65)	\$1,355.04
Retiree & Dependents (all over age 65)	\$2,676.90
Retiree & Dependents (all under age 65)	\$2,855.76

#### CMG High

CMG High option + Consumer Choice Rx	
Retiree (over age 65)	\$1,069.88
Retiree (under age 65)	\$1,290.04
Retiree & Dependents (all over age 65)	\$2,491.74
Retiree & Dependents (all under age 65)	\$2,670.58

CMG Low option + Co-insurance Rx	
Retiree (over age 65)	\$906.64
Retiree (under age 65)	\$1,069.70
Retiree & Dependents (all over age 65)	\$2,163.28
Retiree & Dependents (all under age 65)	\$2,296.52

#### CMG Low

CMG Low option + Consumer Choice Rx	
Retiree (over age 65)	\$841.62
Retiree (under age 65)	\$1,004.70
Retiree & Dependents (all over age 65)	\$1,978.12
Retiree & Dependents (all under age 65)	\$2,111.34

OAP In-Network + Co-insurance Rx	
Retiree (over age 65)	\$1,144.80
Retiree (under age 65)	\$1,367.40
Retiree & Dependents (all over age 65)	\$2,699.16
Retiree & Dependents (all under age 65)	\$2,880.02

#### OAPIN

OAP In-Network + Consumer Choice Rx	
Retiree (over age 65)	\$1,079.78
Retiree (under age 65)	\$1,302.40
Retiree & Dependents (all over age 65)	\$2,514.00
Retiree & Dependents (all under age 65)	\$2,694.84

OAP High option + Co-insurance Rx	
Retiree (over age 65)	\$1,343.90
Retiree (under age 65)	\$1,616.26
Retiree & Dependents (all over age 65)	\$3,147.12
Retiree & Dependents (all under age 65)	\$3,367.82

#### OAP High

OAP High option + Consumer Choice Rx	
Retiree (over age 65)	\$1,278.88
Retiree (under age 65)	\$1,551.26
Retiree & Dependents (all over age 65)	\$2,961.96
Retiree & Dependents (all under age 65)	\$3,182.64

OAP Low option + Co-insurance Rx	
Retiree (over age 65)	\$933.60
Retiree (under age 65)	\$1,103.40
Retiree & Dependents (all over age 65)	\$2,223.96
Retiree & Dependents (all under age 65)	\$2,362.58

#### OAP Low

OAP Low option + Consumer Choice Rx	
Retiree (over age 65)	\$868.58
Retiree (under age 65)	\$1,038.40
Retiree & Dependents (all over age 65)	\$2,038.80
Retiree & Dependents (all under age 65)	\$2,177.40





# COMBINED RATE SHEET

## Monthly Total Medical Rates

(Rates include CIGNA medical, CIGNA pharmacy, CIGNA behavioral health and CIGNA vision coverage)

### Medical Continued

CIGNA Medicare Select Plus Rx	
Retiree Only	\$165.00
Retiree and Spouse	\$330.00

Retiree Enrolled in CIGNA Medicare Select Plus Rx and Others Enrolled in Another Plan	
<i>Retiree in CIGNA Medicare Select Plus Rx &amp; Dependents under age 65 enrolled in:</i>	
CMG High Option with Co-Insurance Pharmacy Plan	\$1,671.16
CMG High Option with Consumer Choice Pharmacy Plan	\$1,550.98
CMG Low Option with Co-Insurance Pharmacy Plan	\$1,397.26
CMG Low Option with Consumer Choice Pharmacy Plan	\$1,277.08

Spouse in CIGNA Medicare Select Plus Rx and Retiree/Dependents under age 65 enrolled in:	
CMG High Option with Co-Insurance Pharmacy Plan	\$1,520.04
CMG High Option with Consumer Choice Pharmacy Plan	\$1,455.04
CMG Low Option with Co-Insurance Pharmacy Plan	\$1,234.68
CMG Low Option with Consumer Choice Pharmacy Plan	\$1,169.68
OAPIN with Co-Insurance Pharmacy Plan	\$1,532.40
OAPIN with Consumer Choice Pharmacy Plan	\$1,467.40
OAP High Option Co-Insurance Pharmacy Plan	\$1,781.26
OAP High Option with Consumer Choice Pharmacy Plan	\$1,716.26
OAP Low Option Co-Insurance Pharmacy Plan	\$1,268.40
OAP Low Option with Consumer Choice Pharmacy Plan	\$1,203.40

### Dental

EDS	
Retiree Only	\$10.00
Retiree + Spouse	\$19.00
Retiree + Child(ren)	\$24.96
Retiree + Family	\$28.76

CIGNA Dental	
Retiree Only	\$32.40
Retiree + Spouse	\$71.44
Retiree + Child(ren)	\$77.28
Retiree + Family	\$99.34

Delta Dental	
Retiree Only	\$40.80
Retiree + Spouse	\$90.00
Retiree + Child(ren)	\$97.32
Retiree + Family	\$125.12



# WHO TO CONTACT

## Maricopa County Employee Health Initiatives Department (Benefits Office)

Maricopa County Administration Building  
301 West Jefferson St., Suite 201  
Phoenix, Arizona 85003-2145  
(602) 506-1010  
Fax: (602) 506-2354  
TTY: (602) 506-1908

EHI Web site: [www.maricopa.gov/benefits](http://www.maricopa.gov/benefits)  
EHI email: [BenefitsService@mail.maricopa.gov](mailto:BenefitsService@mail.maricopa.gov)

### Medical Plans

**CIGNA Medicare Select Plus Rx** - (800) 592-9231  
**Other CIGNA plans** - (800) 244-6224  
**Pre-Enrollment Questions** - (800) 401-4041  
**24-Hour Health Information Line** - (800) 564-8982  
[www.cigna.com](http://www.cigna.com)  
[www.mycigna.com](http://www.mycigna.com)

### Pharmacy Plans

**Walgreens Health Initiatives** - Group #512229  
**Member Services** - (800) 207-2568  
**Prior Authorization** - (877) 665-6609  
**Walgreens Mail Service Member Service** - (888) 265-1953  
**Mail Service Refills** - (800) 797-3345  
**Specialty Pharmacy** - (888) 782-8443  
[www.mywhi.com](http://www.mywhi.com)

### Behavioral Health

**Magellan Health Services** - Group# N/A  
(888) 213-5125  
[www.magellanhealth.com](http://www.magellanhealth.com)

### Vision

**EyeMed Vision Care** - Group #9690793  
**Customer Service** - (866) 724-0782  
**Pre-Enrollment Questions** - (866) 723-0596  
**LASIK** - (877) 552-7376  
[www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)  
[emvision@eyemed.sento.com](mailto:emvision@eyemed.sento.com)

### Dental

**Employers Dental Services** - Group #11931-Plan #300R  
(602) 248-8912 or (800) 722-9772  
[www.mydentalplan.net](http://www.mydentalplan.net)  
**CIGNA Dental** - Group # 2465354  
(888) 336-8258  
[www.mycigna.com](http://www.mycigna.com)  
**Delta Dental** - Group # 4500  
(602) 938-3131 or (800) 352-6132  
[www.deltadentalaz.com](http://www.deltadentalaz.com)



### Retirement

**Arizona State Retirement System** - (602) 240-2000  
Outside Phoenix - (800) 621-3778  
[www.azasrs.gov/web/index.do](http://www.azasrs.gov/web/index.do)  
**Public Safety Retirement System**  
(602) 255-5575  
[www.psprs.com](http://www.psprs.com)  
**Nationwide Retirement Solutions:**  
**Deferred Compensation**  
(602) 266-2733  
(800) 598-4457  
[www.maricopadc.com](http://www.maricopadc.com)

### Other

**Area Agency on Aging**  
(602) 264-2255  
[www.aaa.phx.org](http://www.aaa.phx.org)  
**Community Information & Referral**  
(602) 263-8865  
(800) 3523792  
[www.cirs.org](http://www.cirs.org)